Tip Sheet: Maternal Mental Health

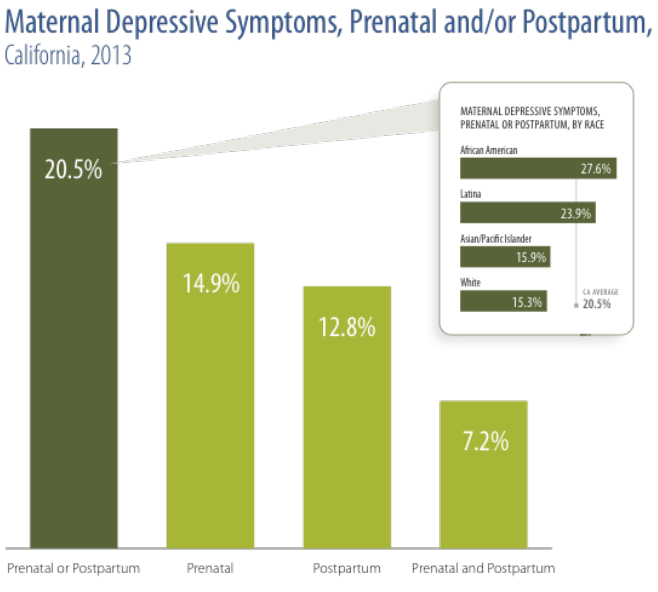
What's the Problem?

The number one complication of pregnancy and childbirth is maternal mental health (MMH) disorders, including depression and anxiety, affecting up to 20% of new mothers during pregnancy and the first year after delivery. A lack of awareness of the problem and understanding among both sufferers and providers causes ineffective and/or lack of diagnosis and treatment.

A combination of factors from biological changes to stressful events that occur during and after pregnancy can cause symptoms of depression, though 50% are never identified. The range of MMH disorders include:

- Depression
- Anxiety disorders, such as panic disorder or generalized anxiety disorder
- Postpartum psychosis—a rare psychological emergency requiring hospitalization; ("postpartum" lasts up to 12 months following birth)

Symptoms of MMH disorders can vary widely depending on the disorder. For example, maternal depression often includes intense and persistent sadness, hopelessness, worthlessness, inadequacy or guilt. Physical symptoms may include headaches or muscle tension. Other symptoms may include a lack of energy, focus or motivation, difficulty making decisions, eating too little or too much, obsessing, sleeping too little/too much, no interest in activities previously enjoyed, withdrawal from friends and family. If symptoms of depression or anxiety last longer than two weeks without treatment, medical attention is required.



Maternity Care in California
Mental Health and Substance Use

In 2013, one in five California women who gave birth had either prenatal or postpartum depressive symptoms.

Rates of prenatal and postpartum depressive symptoms varied by the mother's race/ethnicity. In 2013, about one in four African American and Latina mothers reported depressive symptoms. In contrast, about one in six Asian/Pacific Islander and white mothers reported these symptoms.

Symptoms of anxiety can include extreme worry, inability to sleep or reoccurring thoughts of harm coming to the baby, possibly at the mother's hands (the latter being a case of obsessive compulsive disorder, known as OCD). Psychosis, though less common than depression and the various forms anxiety, is serious; symptoms may include visual or auditory delusions, severe paranoia and a catatonic-like state (staring into space). Because of these breaks from reality, mothers suffering from psychosis are at higher risk of suicide or taking their child's life. It's important not to confuse psychosis with depression or OCD—confusion can perpetuate stigma and prevent women from speaking up.

Who's at Risk?

Up to 20% of women experience some form of depression and/or anxiety during pregnancy or in the first 12 months after delivery. Women with high risk factors are vulnerable for MMH disorders:

- Women with a history of depression, mood or anxiety disorders
- Women with mental illness in the family
- 50% of undiagnosed women
- 68% of women who discontinue antidepressants during pregnancy
- 70% of women with mood disorders, such as bipolar, who discontinue medications during pregnancy

MMH disorders are found in women of every age, culture, income level and race but are more prevalent for underserved populations. Race, poverty or other social factors increase the frequency and severity of mental health conditions. Low-income mothers are 1.4 times more likely than wealthier moms to exhibit depressive symptoms before, during or after pregnancy.

Stressful events during pregnancy and after delivery, such as death of a loved one, emotional or physical abuse and poverty can trigger MMH disorders. Women who experience perinatal loss (stillbirth, miscarriage or neonatal death) are at risk for experiencing MMH disorders during subsequent pregnancies. Another risk factor is the lack of a support system, access to health insurance coverage and/or health care.

Newborns and children exposed to MMH disorders are also at risk. Untreated MMH disorders can result in a fetus with low birth weight and/or born prematurely. MMH disorders can also reduce the mother-infant bond and negatively affect a child's physical and cognitive development, and cause behavioral problems, attention deficit disorder, lower IQ and/or immunity issues.

Many physicians are unaware of the risk of not treating MMH conditions and the fact that it is possible to safely treat pregnant and breastfeeding women with some psychiatric medications. These physicians often incorrectly recommend discontinuing psychiatric medications during and after pregnancy, exacerbating the situation for the patient. In fact, a 2016 survey by Johns Hopkins University's Task Force to Study Maternal Mental Health Report revealed that one in four OB/GYNs lack confidence in knowledge of psychiatric illness, medications and treatment of pregnant and postpartum women.

How Can Maternal Mental Health Disorders Be Treated and Prevented?

Several recommended actions can improve MMH care including:

- Prevention: Increase awareness through patient education of the risks, need to recognize symptoms, asking for help, the importance of sharing feelings and support; reduce the stigma associated with MMH disorders and change the unrealistic concept of a "good mother" that exists today (e.g., always happy, organized, put-together, never angry or upset).

- Screening: Improve early identification through screenings (i.e.: surveying pregnant and new mothers periodically about their mental health); use tests such as Edinburg Postnatal Depression Scale (EPDS) and/or the Patient Health Questionnaire-9 (PHQ9) to access required mental health care from professionals

- Identification: Expand psychiatric training for obstetric, primary care and pediatric providers; provide guidelines for mental health professionals on medications and treatments for pregnant and postpartum women

- Treatment: Provide access to professional treatment and peer support; offer resources for health care if women are not covered by insurance and support services (such as transportation, childcare) so women can get to MMH appointments.

Efforts to improve MMH disorders should address accessing paid family and medical leave, and developing low-cost alternative treatments such as telehealth services and online postpartum depression support groups to make it easier for pregnant and postpartum women to follow through on appointments. Efforts should especially focus on vulnerable populations, such as women with substance use disorders, high-risk pregnancies and victims of domestic violence who are more susceptible to MMH disorders and have high need.

Bottom line

The significant prevalence of MMH disorders requires more attention to identify and treat the condition. The impacts of MMH disorders on mothers, newborns, children and families can be severe but are preventable and/or treatable. Appropriate care can reduce risks and suffering.

Case Study

Jenna lived in a rural town in Pennsylvania. At 34 she gave birth to her third child and felt overwhelmed. Her moods fluctuated with her hormones. She was exhausted from lack of sleep and was easily irritated. Gripped by anxiety and paralyzed with depression, she barely went outside, despite the beautiful summer weather. Too embarrassed to tell friends who seemed happy with all their children, her sense of loneliness and sadness got worse. She felt guilty for not feeling happier about having a healthy baby.

Initially Jenna had handled the demands of a new baby and mothering two young children in stride. But then her new baby daughter struggled with breastfeeding. When her baby

couldn't get a good latch on her nipple, Jenna grew frustrated and stressed. She felt like a failure. When her baby cried to be fed, she couldn't stop crying either. Fearful her daughter wasn't getting nutrition, Jenna lost her appetite. She felt panicky about neglecting her two other boys. Her mood took a dive.

She felt she had no one to turn to. There were few resources in town, and her doctor was 45 minutes away. When she called his office asking for help with breastfeeding, the nurse suggested a lactation specialist. Jenna languished as she tried to find someone. As her condition grew critical, her husband jumped in, insisting that she follow through for their kids' sake. He assured her he'd borrow money, since insurance didn't cover it.

After connecting with La Leche League, Jenna felt relief that her daughter was breastfeeding, but still couldn't shake her depression. Though the medical professionals hadn't recognized her depression, the breastfeeding instructor suspected Jenna's persistent feelings indicated depression MMH disorder. She recommended a free online support group for women suffering from MMH disorders. This helped Jenna realize she wasn't alone. One woman in the group, who lived in a nearby county, spoke about how medication helped.

Jenna hadn't taken antidepressants since college and feared the effects on her milk might harm her baby. But a psychiatrist understood the appropriate drugs and doses for pregnant and breastfeeding women. With the right prescription, care and support from her husband, her fog finally lifted.

Resources

- National Institute for Health Care Management "Identifying and Treating Maternal Depression": https://www.nihcm.org/pdf/FINAL_MaternalDepression6-7.pdf
- Delivering Moms from the Most Common Childbirth Complications: Depression and Anxiety: http://www.chcf.org/articles/2017/07/delivering-moms-childbirth-complications
- Depression During and After Pregnancy: https://www.womenshealth.gov/a-z-topics/depression-during-and-after-pregnancy
- Maternal Depression: https://www.cdc.gov/features/maternal-depression/index.html
- Mom's Mental Health Matters: https://www.nichd.nih.gov/ncmhep/initiatives/moms-mental-health-matters/moms/Pages/default.aspx
- Report of the Task Force to Study Maternal Mental Health: https://www.calhospital.org/sites/main/files/file-attachments/report-cataskforce-proofv7.pd
- Johns Hopkins' Task Force on Maternal Mental Health: http://bit.ly/2vKqVoI
- Postpartum Support International: www.Postpartum.net